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{R 000}	Initial Comments	{R 000}		

On 11/8/2017, a monitoring visit was conducted to assess the assisted living residence's (ALR) compliance with deficiencies cited during their licensure survey completed on 8/3/2017 through 8/24/17. The ALR provided care and supervision to five (5) residents and employs three (3) HHA and one (1) part-time RN. During the monitoring visit, however, 1 of the 5 residents (Resident #5) was hospitalized with a fractured hip after falling from a bed. The findings of the monitoring visit were based on resident observations, resident and staff interviews, record reviews, and an environmental inspection.

On 11/8/2017 at 3:58 p.m., the surveying team identified deficiencies during an environmental inspection that immediately jeopardized residents' health and safety. The assistant living administrator (ALA) was informed at 4:45 p.m. that her use of bed rails caused a resident to be harmed and posed a risk to other residents health and safety.

Note: Listed below are abbreviations used throughout the body of the report.

ALA - Assisted Living Administrator
ALR - Assisted Living Residence
EMS- Emergency Medical Services
HCA - Home Care Agency
HHA - Home Health Aide
ISP - Individual Service Plan
ml - milliliters
PCP - Primary Care Physician
POS- Physician's Order Sheet
RN - Registered Nurse

R 297	Sec. 504.6 Accommodation Of Needs.	R 297		

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R 297	Continued From page 1 (6) To be free of physical restraints at all times; and Based on observation, interview and record review, the ALR failed to ensure each resident had the right to be free from physical restraints at all times, for three (3) of five (5) residents with bed rails attached to their hospital beds. (Residents # 2 and 3) Findings included: 1. On 11/8/17, at approximately 9:40 AM and 2:53 PM, the ALA was interviewed concerning Resident #5's hospitalization. The ALA reported that on 11/4/17, between 8:00 AM and 9:00 AM, the staff heard a "thump" from an upstairs bedroom. The ALA responded immediately and observed resident #5 on the floor near the resident's bed. With assistance from a HHA, the resident was placed back in bed. After complaining of pain and not wanting to be touched, EMS was called (time unknown), two hours after the incident. The resident was transported by EMS to a local hospital and diagnosed with a hip fracture. The ALA was asked to provide more details concerning the resident's fall. The ALA stated that the fall was not witnessed, but the resident had a history of falls from the bed. Prior to the 11/4/17 fall, the resident fell three (3) times by "jumping over the bedrails." The ALA summarized that the resident "jumped over the bedrails" on 11/4/17 because the bedrails were in an upright position. Further interview with the ALA revealed that the resident was non-ambulatory, but due to his mental status, would "jump out" of the bed thinking he could walk. On 11/8/2017, during an environmental inspection, Resident #5's bed was observed to	R 297	Deficient Practice Category: R 297 1.Accommodation of Needs: To be free of physical restraints at all times What corrective action(s) will be accomplished to address the identified deficient practice: •All bedrails were removed and existing residents had their beds placed in their lowest , bedrails have been removed and a mattress was placed on the floor next to the residents bed. •Staff have been made aware to pull the mattresses out when the resident is sleeping and unsupervised and to replace the mattress under the bed during any daily activities with the resident that requires direct care. This will help to prevent stumbling and aid in better maneuvering of the resident. •Staff has been educated on keeping beds in lowest position. •Staff will be educated and trained on policy and procedure regarding resident being free of restraints. •RN will be notified of any resident needing bedrail restraints in order to notify the provider so that an order is placed that will be updated on the ISP and in the residents chart if needed. What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •All bedrails have been removed •Mattresses have been placed on the side of patient beds How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •ALA will monitor staff daily to ensure residents are free of physical restraints. •HHA will do hourly rounds to ensure residents safety.	

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R 297	Continued From page 2	R 297		

have rails on both sides. The bedrails extended from the head to the foot of the bed. The bed was observed at a height that could be lowered, and there were no safety mat observed on the floor next the bed.

On 11/8/17, at 11:15 AM, review of the habilitation and clinical records showed no documented evidence of Resident #5's attempts to climb over the beds and no evidence of any falls.

2. On 11/8/17, at 9:45 AM, Resident #2 and Resident #3 were observed laying in their hospital beds listening to music and watching TV. Both sides of the beds were observed with raised rails that extended from the head to the foot of the bed. The beds were at a height that could be lowered, and there were no safety mat observed on the floor next the beds. Interview with the ALA during this time revealed that the bedrails were used to prevent the residents from falling. The ALA said, "The bed rails are always up when the residents' are in the bed".

At the time of the follow-up visit, the ALR failed to ensure all residents' were free from physical restraints (bed rails) at all times.

On 11/8/17, at 4:45 PM, the ALA were informed that the State Agency (SA) determined at 3:58 PM that the ALR's failure to ensure that residents were free of restraints; and the observed practices of having bedrails up while the residents were in their beds caused harm to Resident #5 and posed an immediate and serious threat to Residents #2 and 3.

On 11/8/2017 at 7:47 PM, prior to the surveyors exiting the ALR, the ALR submitted a corrective action plan and to alleviate and address the

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R 297	Continued From page 3 immediate health and safety concerns: 1. The ALR placed the side bedrails to its lowest position until the side bed rails could be removed from the residents' beds. 2. The ALR lowered the residents' bed to its lowest position. 3. The ALR placed a mattress on the floor beside each resident bed. 4. The ALR staff will make bed checks every 2 hours to ensure the residents' safety. 5. All staff will be instructed to keep the bedrails down, beds at its lowest position, and to ensure mattresses are positioned beside the beds at all times while the residents' are in bed. 6. The bed rails will be removed from each resident's bed within 48 hours. 7. The RN will develop a policy and procedure on ensuring how residents will be free from physical restraints at all times. 8. The RN will train all staff on the policy and procedure to ensure that residents are free from physical restraints at all times.	R 297		
{R 421}	Sec. 602a Resident Agreements (a) A written contract must be provided to the resident prior to admission and signed by the resident or surrogate, if necessary, and a representative of the ALR. The nonfinancial portions of the contract shall include the following: Based on record review and interview, the ALR	{R 421}		

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{R 421}	Continued From page 4 failed to obtain a written resident agreement for one (1) of five (5) residents in the sample. (Resident #5) Findings included: On 11/8/17, at 8:46 AM, review of Resident #5's clinical record showed no documented evidence that the record included a resident agreement. On 11/8/17, at 8:49 AM, the ALA said that the resident's legal guardian would be contacted to sign the resident's agreement and the document would be placed in the clinical record. At the time of the follow-up visit, the ALR failed to ensure a written resident agreement had been obtained for all residents. ********** Based on record review and interview, the ALR failed to obtain a written resident agreement for one (1) of six (6) residents' in the sample. (Resident #5) The finding includes: On August 4, 2017, at 1:30 p.m., review of Resident #5's clinical/administrative record failed to evidence a resident agreement. On August 4, 2017, at 2:00 p.m., interview with the ALA revealed that she would ensure the resident agreement was placed in the record, and that it was signed by the resident's guardian.	{R 421}	Deficient Practice Category: R421 1.Resident Agreements What corrective action(s) will be accomplished to address the identified deficient practice: •All current residents will have newly constructed contracts with appropriate signatures by January 12, 2017 •Newly admitted residents will have contract signed within 24 hours of admission to facility What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •Monthly RN Chart check will be signed off on a monthly basis to ensure that all appropriate signatures have been obtained for resident contracts •Newly admitted resident contracts will be submitted to RN within 24 hours of admission and placed in residents chat How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •Resident Contracts will be monitored monthly through RN chart checks to ensure resident contracts are updated with signatures	
{R 471}	Sec. 604a1 Individualized Service Plans	{R 471}		

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{R 471}	Continued From page 5 (a)(1) An ISP shall be developed for each resident prior to admission. Based on record review and interview, the ALR failed to develop an ISP before admission for one (1) of five (5) residents in the sample. (Resident #6) Findings included: On 11/8/17, at 8:27 PM, review of Resident #6's clinical record showed that the resident was admitted on 8/5/17. Further review of the record showed no documented evidence that an ISP had been developed before the resident's admission to the ALR. On 11/8/17, at 8:32 PM, the ALA said that Resident #6's ISP was not developed before the resident's admission to the ALR because the RN was not notified of the resident's pending admission. At the time of the follow-up visit, the ALR failed to ensure an ISP had been developed before the resident's admission to the ALR. ********** Based on record review and interview, the ALR failed to develop an ISP before admission for two (2) of two (2) newly admitted residents in the sample. (Residents #4 and #5) The findings include: I. On August 4, 2017, at 12:30 p.m., review of Resident #4's clinical record revealed that the resident was admitted on June 21, 2016. Continued review of the record lacked documented evidence a pre-admission ISP had	{R 471}	Deficient Practice Category: R471 1.Pre-Admission Individual Service Plans What corrective action(s) will be accomplished to address the identified deficient practice: •All new residents will have pre-admission ISP's completed (10) days prior to admission to assess their needs at the facility. ISP's will then be faxed to the DOH for review (10) days prior to admission What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •ALA will communicate to the RN any potential residents for admission (10) days prior to anticipated admission How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •RN will be notified by ALR (15) days prior to admission with potential residents. RN will inquire with ALA monthly of any potential residents for admission	

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{R 471}	Continued From page 6 been developed. II. On August 4, 2017, at 1:30 p.m., review of Resident #5's clinical record revealed that the resident was admitted on January 4, 2017. Continued review of the record lacked documented evidence a pre-admission ISP had been developed. On August 4, 2017, at 2:30 p.m., interview with the ALA revealed that she was unaware that the residents mentioned above pre-admission ISPs had not been developed. Further interview revealed she would ensure the nurse, who is contracted to develop and update ISPs, develop pre-admission ISP's for all prospective resident going forward. At the time of the survey, the ALR failed to ensure pre-admission ISPs had been developed.	{R 471}		
{R 472}	Sec. 604a2 Individualized Service Plans (2) An ISP shall be developed following the completion of the "post move-in" assessment. Based on record review and interview, the ALR failed to ensure an ISP had been developed after the post move-in assessment for two (2) of five (5) residents in the sample. (Residents #5 and 6) Findings included: 1. On 11/8/17, at 8:40 PM, review of Resident #5's clinical record showed that the resident was admitted on 1/14/17. Further review of the record showed no documented evidence that an ISP had been developed following the post move-in assessment.	{R 472}		

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{R 472}	Continued From page 7	{R 472}		

2. On 11/8/17, at 8:45 PM, review of Resident #6's clinical record showed that the resident was admitted on 8/9/17. Further review of the record showed no documented evidence that an ISP had been developed following the post move-in assessment.

On 11/8/17, at 8:55 PM, the ALA said that Resident #5 and 6's ISPs were not developed following the post move-in assessments because the RN was not able to complete the ISPs prior to going on leave.

At the time of the follow-up visit, the ALR failed to ensure ISPs had been developed following the post-move in assessments.

****

Based on record review and interview, the ALR failed to ensure an ISP had been developed after the post move-in assessment for two (2) of two (2) residents in the sample.
(Residents #4 and #5)

The findings include:

I. On August 4, 2017, at 12:30 p.m., review of Resident #4's clinical record revealed that the resident was admitted on June 21, 2017. Further review of the record lacked evidence that an ISP had been developed following the post move-in assessment.

II. On August 4, 2017, at 1:30 p.m., review of Resident #5's clinical record revealed that the resident was admitted on January 14, 2017. Further review of the record lacked evidence a ISP had been developed following the post

Deficient Practice Category: R472

1.Post Move-in Individualized Service Plans

What corrective action(s) will be accomplished to address the identified deficient practice:

•All newly admitted residents will have (30) day post move-in ISP's developed and placed in chart
What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur

•RN Monthly chart checklist will be checked off monthly for any post move-in ISPs

•Residents Summary Report will be submitted to DOH on a monthly basis by the first of each month beginning January 1, 2018

How the Corrective action(s) will be monitored to ensure the deficient practice will not recur.

•RN Monthly chart checks include checkoff of any ISP updates

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{R 472}	Continued From page 8 move-in assessment. On August 4, 2017, at 2:30 p.m., interview with the ALA revealed that she was unaware that the residents mentioned above post move-in ISPs had not been developed. Further interview revealed she would ensure the nurse, who is contracted to develop and update ISPs, develop post move-in ISP's for all newly admitted residents going forward. At the time of the survey, the ALR failed to ensure ISPs had been developed following the post-move in assessment.	{R 472}	Deficient Practice Category: R473 1.Healthcare Practitioner-Individualized Service Plans What corrective action(s) will be accomplished to address the identified deficient practice: •All Resident ISP's will be created, updated and signed off by "Healthcare Practitioner" and not the contracted RN What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur: RN will make assessments and relay to the ALA what the Healthcare Practitioner should focus on during their updated ISP assessments •RN monthly checklist will checkoff if healthcare practitioner has written and signed off on all new and updated ISP's How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •RN Monthly chart checks will be done to determine residents needing updated ISP's	
{R 473}	Sec. 604a3 Individualized Service Plans (3) The ISP shall be written by a healthcare practitioner using information from the assessment. Based on record review and interview, the ALR failed to have ISPs written by a healthcare practitioner for four (4) of five (5) residents in the facility. (Residents #1, 3, 5 and 6) Findings included: On 11/8/17, at 8:05 PM, review of the Resident #1, 3, 5 and 6's clinical records showed no documented evidence that the ISPs had been written by a healthcare practitioner. On 11/8/17, at 8:10 PM, the ALA said that only Resident #2's ISP was written and approved by a healthcare practitioner. The ALA said that Resident #1, 3, 5 and 6's healthcare practitioners would be contracted to write and approve the resident's ISPs.	{R 473}		

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{R 473}	Continued From page 9 At the time of the follow-up visit, the ALR failed to ensure that all resident's ISPs were written by a healthcare practitioner. ********** Based on record review and interview, the ALR failed to have ISPs written by a healthcare practitioner for five (5) of six (6) residents in the facility. (Residents #1, #2, #3, #4, and #5) The finding includes: On August 4, 2017, from 10:25 a.m. to 3:00 p.m., review of Resident's (#1, #2, #3, #4 and #5) clinical/administrative records each lacked documented evidence that the ISPs had been written by a healthcare practitioner. On August 4, 2017, at 3:00 p.m., interview with the assisted living manger revealed that she would ensure that healthcare practitioners write all ISP's going forward. At the time of the survey, the ALR failed to ensure that each resident's ISP was written by a healthcare practitioner.	{R 473}		
{R 475}	Sec. 604a5 Individualized Service Plans (5) The ISP shall be signed by the resident, or surrogate, and a representative of the ALR. Based on record review and interview, the ALR failed to ensure the ISP was signed by the resident, surrogate or a representative of the ALR for four (4) of five (5) residents in the facility. (Residents #1, 3, 5 and 6) Findings included:	{R 475}		

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{R 475}	Continued From page 10 On 11/8/17, at 8:15 PM, review of Resident #1, 3, 5 and 6's ISPs showed no documented evidence that the aforementioned resident's ISPs were signed by the resident or surrogate. On 11/8/17, at 8:17 PM, the ALA said only Resident #2's ISP was signed by the residents' surrogate. The ALA said that Resident #1, 3, 4, 5 and 6's surrogates would be contacted to sign the residents ISPs. At the time of follow-up visit, the ALR failed to ensure that each resident's ISP was signed by the resident or their surrogate. ********** Based on record review and interview, the ALR failed to ensure the ISP was signed by the resident and a representative of the ALR for five (5) of six (6) residents in the facility. (Residents #1, #2, #3, #4 and #5) The findings include: On August 4, 2017, from 10:25 a.m. to 3:00 p.m., review of Residents' (#1, #2, #3, #4 and #5) ISPs were reviewed and revealed that each was signed by only the facility's RN. On August 4, 2017, at 3:12 p.m., interview with the ALA revealed that she would ensure that the residents' surrogate also signed the ISPs going forward. At the time of survey, the facility failed to ensure that each resident's ISP was signed by the resident or their surrogate.	{R 475}		

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{R 481}	Sec. 604b Individualized Service Plans (b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed. Based on observation, interview and record review, the facility failed to document on each resident's ISP when, how often, and by whom services would be provided for two (2) of five (5) residents in the facility. (Residents #1 and 2) Findings included: I. The facility's RN failed to ensure Resident #1's ISP had been updated to include the services provided by the HCA, as evidenced by: On 11/8/17, at 10:35 AM, observations showed HHA #2 sitting beside Resident #1 at a table in the dining room actively engaged in helping the resident color a picture. On 11/8/17, at 10:40 AM, the ALA said Resident #1 received HHA services twelve (12) hours a day from an HCA seven (7) days a week. On 11/8/17, at 11:00 AM, review of Resident #1's ISP showed no documented evidence of the HHA services the resident was provided daily. At the time of the follow-up visit, the facility failed to include who, when, and how often the HHA services were to be provided for the resident. II. The facility's RN failed to review Resident #2's ISP to ensure the changes in the resident's healthcare had been updated on the ISP, as evidenced by:	{R 481}		

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{R 481}	Continued From page 12 1. On 11/8/17, at 11:00 AM, observations showed Resident #2 lying in a hospital bed with both bedrails in the upright position. Wound dressings were observed on both hips and extremities at that time. On 11/8/17, at 11:10 AM, review of Resident #2's POS, dated 8/10/17, prescribed the following wound care: The right hip and sacrum was to be cleaned with wound care cleanser; Patted dry; Packed with Calcium Alginate; and Covered with gauze or an abdominal pad every other day and whenever necessary. Further review of the POS prescribed the following wound care: The left hip was to be cleaned with wound care cleanser; Patted dry; Apply Hydro gel; and Cover with gauze or an abdominal pad every other day and whenever necessary. Additionally, the order required that bi-lateral extremity wounds were to be cleaned, patted dry, and covered with foam dressing every other day and, as needed. On 11/8/17, at 11:38 AM, the ALA reported that Resident #2 was to receive wound care by a Hospice RN three (3) days a week. At the time of the follow-up visit, the ALR failed to ensure the resident's ISP was updated to include when, how often, and by whom wound care would be provided.	{R 481}		

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{R 481}	Continued From page 13	{R 481}		

2. On 11/8/17, at 11:45 AM, observations showed Resident #2 lying in a hospital bed with both bedrails in the upright position. Further observations showed the resident with an external catheter attached to a urinary drainage bag.

On 11/8/17, at 11:47 AM, the ALA said Resident #2 had on an external catheter to protect the wounds from being contaminated by urine.

On 11/8/17, at 11:50 AM, review of Resident #2's POS, dated 9/7/17, showed the resident was ordered an external catheter as needed for incontinence management.

On 11/8/17, at 1:00 PM, review of Resident #2's ISP, dated 2/3/17, showed no documented evidence of when, how often, and by whom incontinence management would be provided as ordered by the PCP.

At the time of the follow-up visit, the ALR failed to ensure the resident's ISP was updated to include incontinence management.

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Based on interview and record review, the facility failed to document on each resident's ISP when, how often, and by whom services would be provided for four (4) of six (6) residents in the facility. (Residents #1, #2, #3 and #4)

The findings include:

I. On August 3, 2017, at 10:05 a.m., interview with the ALA revealed that Resident #1 received HHA services twelve (12) hours per day from a HCA.

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{R 481}	Continued From page 14	{R 481}		

On August 4, 2017, at 11:09 a.m., review of Resident #1's ISP failed to document who provided HHA services and how often.

II. On August 3, 2017, at 10:05 a.m., interview with the ALA revealed that Resident #2 had multiple wounds and was also receiving hospice services.

On August 4, 2017, at 10:25 a.m., review of Resident #2's ISP failed to document who provided hospice care and how often. Additionally, the ISP failed to document what wound care treatment the resident received, and how often.

III. On August 3, 2017, at 10:05 a.m., interview with the ALA revealed that Resident #3 received hospice service from an outside agency.

On August 4, 2017, at 12:26 p.m., review of Resident #3's ISP failed to document that the resident received hospice services, and how often.

On August 4, 2017, at 3:12 p.m. interview with the ALA revealed that she would ensure the nurse updated each resident's ISP when, how often, and by whom services would be provided.

IV. On August 9, 2017 at 1:26 p.m., an unidentified woman was observed entering the facility. The woman walked to Resident #4's bedroom.

Minutes later, the ALA stated that the woman was an aide that comes in each day to "dry" the resident and change the resident's adult protective undergarments. The ALA further stated

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{R 481}	Continued From page 15 that the aide used to provide services for the resident when he/she was on hospice. The ALA asked the aide to continue to provide services after hospice was discontinued. The ALA also stated that the aide was not an employee, and is paid "under the table" for the services provided. When asked if the facility's nurse provided any training for the aide, the ALA stated that the RN was not aware that the aide provided services to Resident #4. It should be noted that the aide's name was obtained and verified as a certified HHA via the Washington D.C., Board of Nursing online database. On August 9, 2017, at 1:40 p.m., review of Resident #4's ISP failed to document that an aide comes in daily to provide personal care services. At 1:43 p.m., the ALA was informed that the private aide was not documented on the ISP. The ALA responded that she was unaware that the use of a private aide had to be listed on the ISP. At the time of the survey, the ALR failed to include who, when, and how often all services were to be provided for the aforementioned residents.	{R 481}		
{R 483}	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by	{R 483}		

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{R 483}	Continued From page 16 an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. Based on observation, interview and record review, the ALR failed to ensure that each resident's ISP was updated with significant changes, for three (3) of six (6) residents in the sample. (Residents #2, 4, and 5) Findings included: 1. On 11/8/17, at approximately 9:40 AM and 2:53 PM, the ALA was interviewed concerning Resident #5's hospitalization. The ALA reported that on 11/4/17, between 8:00 AM and 9:00 AM, the staff heard a "thump" from an upstairs bedroom. The ALA responded immediately and observed resident #5 on the floor near the resident's bed. After complaining of pain and not wanting to be touched, EMS was called (time unknown), two hours after the incident. The resident was transported by EMS to a local hospital and diagnosed with a right hip fracture. The ALA was asked to provide more details concerning the resident's fall. The ALA stated that the fall was not witnessed, but the resident had a history of falls from the bed. Prior to the 11/4/2017 fall, the resident fell 3 times by "jumping over the bedrails." On 11/8/17, at 2:15 PM, the ALA said during an interview that Resident #5's falls, right hip fracture, and admittance to the hospital was not documented in the resident's ISP. On 11/8/17, at 2:20 PM, review of Resident #5's ISP, dated 2/3/17, showed no documented evidence of the significant changes in the resident's health care status.	{R 483}	Deficient Practice Category: R483 1.30 Day Review -Individualized Service Plans What corrective action(s) will be accomplished to address the identified deficient practice: •Within 30 days of admission and 6 months after admission ISP's will be updated and signed by Healthcare Practitioner Significant changes to residents will be made aware to RN by ALA so that ISP's are updated to reflect changes to residents status. •Surrogate, ALR and Healthcare practitioner will participate to be made aware of changes to residents status What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •RN will complete monthly chart checklist to ensure ISP's that require 30 day post admission updates or significant changes are complete •ALA will submit monthly summary to DOH indicating all significant updates to ISP How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •RN Monthly chart checks will be done to monitor that all services are updated and present on the residents ISP's	

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{R 483}	Continued From page 17	{R 483}		

At the time of the follow-up visit, the ALR failed to ensure the resident's ISP was updated to include the resident's fall, fractured right hip and hospitalization.

2. On 11/8/17, at 9:55 AM, the ALA said during and interview that Resident #4 was observed lying in bed on 9/27/17, drooling from the mouth and exhibiting signs of a stroke. The ALA said 911 was called and Resident #4 was transported to the emergency room via EMS, admitted and died on 9/30/17, in the hospital.

On 11/8/17, at 10:00 AM, the ALA said that Resident #4's change in mental status, transfer, and admittance to the hospital was not documented in the resident's medical record.

At the time of the follow-up visit, the ALR failed to ensure the resident's ISP was updated to include the significant change in the resident's health care status and hospitalization.

3. On 11/8/17, at 11:00 AM, observations showed Resident #2 lying in a hospital bed with both bedrails in the upright position. Wound dressings were observed on both hips and extremities at that time.

On 11/8/17, at 11:10 AM, review of Resident #2's POS, dated 8/10/17, prescribed the following wound care:

The right hip and sacrum was to be cleaned with wound care cleanser;
Patted dry;
Packed with Calcium Alginate; and
Covered with gauze or an abdominal pad every other day and whenever necessary.

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{R 483}	Continued From page 18 On 11/8/17, at 11:38 AM, the ALA reported that Resident #2 was to receive wound care by a Hospice RN three (3) days a week. On 11/8/17, at 1:00 PM, review of Resident #2's ISP, dated 2/3/17, showed no documented evidence that specific wound care management was included in the ISP. At the time of the follow-up visit, the facility failed to ensure the resident's ISP was updated to include specific wound care management. 4. On 11/8/17, at 10:18 AM, observations showed Resident #2 was positioned on the left side and had on an external catheter which was attached to a urinary drainage bag. On 11/8/17, at 10:25 AM, the ALA said Resident #2 was wearing an external catheter to protect the hip and leg wound dressings from being contaminated by urine. On 11/8/17, at 12:00 PM, review of Resident #2's POS, dated 9/7/17, showed the resident was ordered an external catheter as needed for incontinence. On 11/8/17, at 1:15 PM, review of Resident #2's ISP, dated 2/3/17, showed no documented evidence that the external catheter ordered by the PCP was included in the ISP. At the time of the follow-up visit, the ALA failed to ensure the resident's ISP was updated to include the use of an external catheter for urinary incontinence. **********	{R 483}		

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{R 483}	Continued From page 19	{R 483}		

Based on interview and record review, the AR failed to ensure that each resident's ISP was updated with significant changes, for two (2) of six (6) residents. (Residents #2 and #3)

The findings include:

I. On August 3, 2017, at 10:05 a.m., interview with the ALA revealed that Resident #2 acquired multiple new wounds in "the last few months" on his/her hips that were being treated.

On August 4, 2017, at 10:25 a.m., review of Resident #2's medical record revealed an ISP, dated February 3, 2017. The ISP documented that the resident had a pressure ulcer on his/her foot. The ISP failed to evidence the new hip wounds and the treatment for each.

II. On August 3, 2017, at 10:05 a.m., interview with the ALA revealed that Resident #3 received hospice service from an outside agency since January of 2017.

On August 4, 2017, at 12:26 p.m., review of Resident #3's medical record revealed ISP's, dated "October 2016" and "May 2017". Review of the ISP's lacked evidence that they had been updated with hospice services.

On August 4, 2017, at 3:12 p.m., interview with the ALA revealed that the facility's nurse made monthly visits to update the medical records, including the ISP's. The ALA further stated that she will ensure that the nurse update the ISP's with significant changes going forward.

At the time of survey, the AR failed to ensure that each resident's ISP reflected the changed in their

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{R 483}	Continued From page 20 health status.	{R 483}		
R 601	Sec. 701e Staffing Standards. (e) Newly hired staff shall have 30 days to document their communicable disease status. For the purposes of this subsection, "newly hired staff" means any individual who is hired by an ALR regardless of the individual's previous work experience. An employee who is transferring from one ALR to another ALR that is under the same management or ownership, without break in service, shall not be considered newly hired staff. Based on record review and interview, the ALR failed to (I) ensure that all employees had documented evidence of their communicable disease status in their personnel file for one (1) of 1 part-time nurse and (II) ensure that all HCA staff had documented evidence of their communicable disease status in their personnel file for 1 of four (4) HHAs. (RN and HHA #7) Findings included: I. On 11/8/17, beginning at 10:55 AM, review of the ALR's RN personnel file revealed that the RN was hired on 6/17/16. Further review of the personnel file failed to show evidence that the RN had been cleared of any communicable disease. At 10:58 AM, the ALA said that the RN did have written documented evidence of a communicable disease clearance. However, there was no additional information given to the surveyor prior to the end of the monitoring visit. At the time of the follow-up visit, the ALR failed to ensure all employees personnel files included a current communicable disease status.	R 601	Deficient Practice Category: R601 1.Staffing Standards – History & Physicals/ Communicable diseases What corrective action(s) will be accomplished to address the identified deficient practice: All newly hired staff will provide proof of history & physical, communicable disease status and license within 30 days of hire to the ALA for personal file. What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •ALR will submit proof of all newly hired H&P, communicable disease and license status to the DOH within 30 days of hire. How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •ALR will submit summary to DOH on the 1st of the month	

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R 601	Continued From page 21 II. On 11/8/17, at 11:00 AM, review of the personnel records revealed no documented evidence of a personnel file for HHA #7 in the ALR. At 11:02 AM, the ALA said that the HHA #7 did have written documented evidence of a communicable disease clearance. However, there was no additional information given to the surveyor prior to the end of the monitoring visit. At the time of the follow-up visit, the ALR failed to ensure that all HCA staff had documented evidence of their communicable disease status.	R 601		
R 602	Sec. 701f Staffing Standards. (f) Employees shall be required on an annual basis to document freedom from tuberculosis in a communicable form. Based on record review and interview, the ALR failed to ensure that each employee was free from tuberculosis for one (1) of one (1) part-time RN working in the ALR. (RN) Findings included: On 11/8/17, beginning at 11:05 AM, review of the personnel records showed the RN was hired on 6/17/16. Further review of the record showed no documented evidence that the RN had the TB employee symptom assessment in 2017. At 3:05 PM, interview with the ALA confirmed that the RN did not have a tuberculosis screening in the file. At the time of the survey, the personnel file lacked evidence that RN was from free from tuberculosis in a communicable form.	R 602	Deficient Practice Category: R602 1.Staffing Standards- Immunizations What corrective action(s) will be accomplished to address the identified deficient practice: •All newly hired staff will provide TB freedom from in a communicable form within 30 days of hire to the ALR for personal file. •ALR will have on file updated immunization record of RN and newly hired staff What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •ALR will submit proof of all newly hired & RN TB communicable disease form within 30 days of hire How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •ALR will submit summary to DOH on the 1st of the month	

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R 605	Continued From page 22	R 605		
R 605	Sec. 701g2 Staffing Standards. (2) Possess current and appropriate licensure and certifications as required by law; Based on interview and record review, the ALA failed to ensure that all staff possessed appropriate certification prior to employment, for one (1) of four (4) HHA records reviewed. (HHA #7) Findings included: On 11/8/17, beginning at 10:55 AM, all personnel records were requested for review. However, there was no personnel file available for review for HHA #7 in the facility. On 11/8/17, at 11:20 AM, interview with the ALA it was indicated they would check the files and provide the surveyor with HHA #7's personnel file. There was no additional information given to the surveyor prior to the end of the monitoring visit.	R 605	Deficient Practice Category: R605 1.Staffing Standards- Licensure What corrective action(s) will be accomplished to address the identified deficient practice: •All newly hired staff will provide proof of Licensure and a copy for ALA personal file What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur: •ALR will submit proof of all newly hired license status to the DOH within 30 days of hire. How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •ALR will submit summary to DOH on the 1st of the month	
R 670	Sec. 702b1 Staff Training. (1) Their specific duties and assignments; Based on observation, interview and record review, the ALR failed to ensure that all staff within seven (7) days of employment was adequately trained to (I) use a 60 ml syringe to orally feed a resident safely; (II) operate the external wheelchair lift safely; and (III) operate the internal electric chair stair lift safely, for five (5) of 5 residents in the sample. (Resident #1, 2, 3, 5 and 6) Findings included: I. The ALR's RN failed to ensure all staff had	R 670		

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R 670	Continued From page 23 been trained on orally feeding Resident #3 safely with a 60 ml syringe, as evidenced below: On 11/8/17, at 5:15 PM, observations showed HHA #2 feeding Resident #3 a pureed diet that included oatmeal, applesauce, milk and a supplemental drink separately via a 60 ml syringe. The syringe was repeatedly filled at 30 mls, positioned beyond the front gums on the left side of the resident's mouth and released slowly. At the end of each feeding, the resident said "one more" until 100 % of the pureed food and 240 ml of the liquids had been consumed. Further observations showed that the resident's hospital bed was positioned at a 45 degree angle during and after the feeding. On 11/8/17, at 5:50 PM, HHA #2 said the ALR's RN had not provided any training on the use of a 60 ml syringe for oral feedings. However, HHA #2 said that Resident #3's hospice nurse had trained some of the staff on the use of a 60 ml syringe for oral feeding. On 11/8/17, at 6:30 PM, when questioned about the aforementioned training, the ALA said that all staff had not been trained by the ALA's RN on feeding Resident #3 with a 60 ml syringe. The ALA also said that there was no documented evidence of the trainings available for review. On 11/8/17, at 6:38 PM, review of Resident #3's POS, dated 8/16/17, showed the PCP ordered the resident to be fed with a 60 ml syringe for oral feedings that included pureed food, liquids, and supplemental drinks. On 11/8/17, at 6:41 PM, review of the ALR's staff training records showed no documented evidence of training on the use of a 60 ml syringe to	R 670	Deficient Practice Category: R670 1.Staff Training – Device training for Current & New hires What corrective action(s) will be accomplished to address the identified deficient practice: •All newly hired staff within (7)days of employment will have adequate training on how to use the 60 ml syringe for oral feeding •All newly hired staff within (7)days of employment will have adequate training on how to use and operate the internal electric chair stair lift •All newly hired staff within (7)days of employment will have adequate training on how to use and operate the external wheelchair lift •RN will provide adequate training to current hires on how to utilize the 60 ml syringe for oral feeding and HHA training will be signed of by January 12, 2018 •RN will provide adequate training to current hires on how to utilize and operate the external wheelchair lift and internal chair lift will be signed of by January 12, 2018 What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •RN will be made aware by ALR of any new devices for residents that might require training within (5) days so that appropriate training is provided to staff. •ALR will keep personal files of current and new hires with appropriate training that has been signed off on. How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •ALR will communicate with RN regarding all new hires needing device training.	

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R 670	Continued From page 24 provide oral feedings to Resident #3. At the time of the follow-up visit, the ALR failed to ensure all staff was trained on the use of a 60 ml syringe to provide oral feedings. II. The ALR failed to ensure all staff had been trained to safely operate the external wheel chair lift, as evidenced by: On 11/8/17, at 3:10 PM, the external chair lift was observed to be operable when tested by the ALA. At 6:55 PM, review of the ALR's training records showed no documented evidence that staff had been trained to operate the external wheelchair lift. On 11/8/17, at 6:57 PM, interview with the ALA said that staff had not been trained to operate the external wheelchair lift for the residents. III. The ALR failed to ensure all staff had been trained to safely operate the internal electric chair lift, as evidenced by: On 11/8/17, at 3:20 PM, the internal electric chair lift was observed to be operable when tested by the ALA. When asked about training, the ALA indicated that staff had previously been trained on the old internal electric chair system, but the training was not documented. The ALA said that staff had not been trained on the current internal electric chair lift. On 11/8/17, at 6:59 PM, review of personnel records for staff training showed that staff had not been trained to operate the current internal electric chair lift.	R 670		

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R 675	Continued From page 25	R 675		
R 675	Sec. 702b6 Staff Training. (6) The emergency procedures and disaster drills and techniques of complying, including evacuating residents when applicable; Based on record review and interview, the ALR failed to ensure new employees were trained on emergency procedures and disaster drills including the use of fire mats, for three (3) of four (4) in the ALR. (RN, HHA #2 and HHA 5) Findings included: 1. On 11/8/17, beginning at 10:55 AM, review of the ALR's RN personnel file revealed that the RN was hired on 6/17/16. Further review of the personnel file failed to show evidence that the RN had been trained on the emergency procedures and disaster drills, including the use of fire mats. 2. On 11/8/17, at 11:03 AM, review of HHA #2's personnel file revealed that the HHA was hired on 8/9/17. Further review of the personnel file failed to show evidence that HHA #2 had been on trained the emergency procedures and disaster drills, including the use of fire mats. 3. On 11/8/17, at 11:05 AM, review of HHA #5's personnel file revealed that the HHA was hired on 6/17/17. Further review of the personnel file failed to show evidence that HHA #5 had been trained on the emergency procedures and disaster drills, including the use of fire mats. On 11/8/17, at 3:05 PM, the ALA said that newly hired employees had been trained on emergency procedures and disaster drills. When asked to provide the surveyor with evidence of training, the ALA said that the emergency procedures and disaster trainings were documented in the	R 675	Deficient Practice Category: R675 1.Staff Training- Emergency/Disaster Drills What corrective action(s) will be accomplished to address the identified deficient practice: •All newly hired staff will have training on emergency procedures and disaster drills including the use of fire mats and a copy will be placed in HHA personal file What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •ALR will conduct monthly personal file assessment to determine the need for updates or additions How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •ALR will submit summary to DOH on the 1st of the month	

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R 675	Continued From page 26 employee files. At the time of the follow-up visit, the ALR failed to ensure newly hired employees had been trained on the emergency procedures and disaster drills, including the use of fire mats.	R 675		
{R 784}	Sec. 901 3 Responsibilities Of The ALR Personnel (3) Requires that medications be administered by a TME or a licensed nurse. Based on record review and interview, the RN failed to conduct an initial medication assessment, for three (3) of 3 newly admitted residents. (Residents #4, 5 and 6) Findings included: 1. On 11/8/17, at 7:48 PM, review of Resident #4's clinical record showed the resident was admitted on 6/21/17. Further review of the record showed the RN had not conducted an initial medication assessment to determine the resident's need for medication administration. On 11/8/17, at 7:50 PM, the ALA said the RN had not conducted an initial medication assessment on Resident #4 prior to the resident's death. 2. On 11/8/17, at 7:48 PM, review of Resident #5's clinical record showed the resident was admitted on 6/21/17. Further review of the record showed the RN had not conducted an initial medication assessment to determine the resident's need for medication administration. On 11/8/17, at 7:50 PM, the ALA said the RN had not conducted an initial medication assessment	{R 784}	Deficient Practice Category: R784 1.Responsibility of ALR personnel What corrective action(s) will be accomplished to address the identified deficient practice: •RN will conduct Initial medication assessments within 24 hours of admission of all new residents What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •RN Monthly chart checklist will be checked off monthly to document any new admissions and their initial medication assessments How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •RN will conduct a monthly chart check and sign off if there is a need for any initial medication assessments on residents	

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{R 784}	Continued From page 27	{R 784}		

on Resident #5 prior to the resident's transfer to the hospital on 11/4/17.

3. On 11/8/17, at 8:27 PM, review of Resident #6's clinical record showed that the resident was admitted on 8/5/17. Further review of the record showed the RN had not conducted an initial medication assessment to determine the resident's need for medication administration.

On 11/8/17, at 7:50 PM, the ALA said the RN had not conducted an initial medication assessment on Resident #6 to determine the resident's need for medication administration.

At the time of the follow-up visit, the ALR's RN failed to conduct an initial medication assessment on all residents.

****

Based on record review and interview, the RN failed to conduct an initial medication assessment, for two (2) of two (2) newly admitted resident. (Residents #4 and #5)

The findings include:

I. On August 4, 2017, at 12:30 p.m., review of Resident #4's clinical record revealed that the resident was admitted on June 21, 2016. Further review of the record lacked documented evidence the RN conducted an initial medication assessment to determine the resident's need for medication administration.

II. On August 4, 2017, at 1:30 p.m., review of Resident #5's clinical record revealed that the resident was admitted on June 21, 2016. Further

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{R 784}	Continued From page 28 review of the record lacked documented evidence the RN conducted an initial medication assessment to determine the resident's need for medication administration. On August 4, 2017, at 3:30 p.m., interview with the ALA revealed that she had administered medications to the residents mentioned above since their admission. Continued interview revealed that she was unaware that the RN had not conducted initial medication assessments; however, she would ensure the RN conduct an initial assessment for all newly admitted residents going forward. At the time of the follow-up visit, the RN failed to conduct an initial medication assessment for Residents #4 and #5.	{R 784}		
{R 802}	Sec. 903 2 On-Site Review. (2) Assess the resident's response to medication; and Based on interview and record review, the facility failed to ensure that the RN assessed each resident's response to their medication every 45 days, for four (4) of five (5) residents that received medications. (Residents #1, 2, 3, and 6) Findings included: On 11/8/17, at 11:45 AM, review of Resident #1, 2, 3, and 6's medical records showed the facility's RN had not assessed the aforementioned residents' response to their prescribed medications every 45 days. On 11/8/17, at 11:48 AM, the ALA said the RN had not completed Resident #1, 2, 3, and 6's 45	{R 802}	Deficient Practice Category: R802 1.On-Site Review What corrective action(s) will be accomplished to address the identified deficient practice: •RN will conduct 45 day medication response during monthly visits on all current residents What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •RN Monthly chart checklist will be checked off monthly to document that 45 day medication response has been completed How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •RN will conduct a monthly chart check and sign off that the 45 day medication response	

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{R 802}	Continued From page 29 day medication assessments, as required by the regulations. However, the ALA said that the RN would complete all of the resident's 45 day medication assessments upon returning to the facility. At the time of the follow-up visit, the ALR failed to ensure that each resident was assessed for a response to their medications every 45 days. ********** Based on interview and record review, the facility failed to ensure that the RN assessed each resident's response to their medication every 45 days for five (5) of (5) residents. (Residents #1, #2, #3, #4 and #5) The findings include: On August 4, 2017, from 10:25 a.m. to 3:00 p.m., review of Residents' (#1, #2, #3, #4 and #5) medical records failed to evidence that the facility's RN assessed the residents' response to their prescribed medications. On August 4, 2017, at 3:12 p.m., interview with the ALA revealed that the RN had a contract to come to the facility once per month to update the residents' medical records. The ALA further stated that she would ensure that the RN would assess the residents' response to medication going forward. On August 4, 2017, at 4:41 p.m., review of the RN's contractor agreement revealed that assessing the residents' response to medication was not documented as part of the nurse's services.	{R 802}		

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{R 802}	Continued From page 30 Interview with the facility's RN on August 3, 2017, at 5:00 p.m., revealed that she did not perform any additional duties outside of what was listed on her contract. At the time of survey, the facility failed to ensure that each resident was assessed for response to their medications every 45 days.	{R 802}		
{R 821}	Sec. 904e8 Medication Storage (8) Residents who self-administer may keep and use prescription and nonprescription medications in their units as long as they keep them secured from other residents. Based on observation and interview, the facility failed to ensure that only residents who self-administered kept medications in the units, for one (1) of six (6) residents in the sample. (Resident #2) Findings included: On 11/8/17, at 4:45 PM, observation of an unlocked storage closet adjacent to Resident # 2's room showed an unlocked medication box containing Fentanyl patches and Dilaudid tablets. On 11/8/17, at 4:47 PM, the ALA said that combination locks had been purchased for the storage closet and the plastic box containing Fentanyl patches and Dilaudid. The ALA said that additional locks would be purchased for both the storage closet and the medication box to comply with state regulations. At the time of the follow-up visit, the ALR's storage closet and medication box was unlocked that contained Resident #2's Fentanyl patches	{R 821}	Deficient Practice Category: R821 1.Medication Storage What corrective action(s) will be accomplished to address the identified deficient practice: •Locks have been purchased and ALA will keep the medication of all non self-administering residents in a locked cabinet or box to prevent other residents from obtaining the medication •Locks have been purchased and ALA will keep narcotics in a locked box with a key only accessible to the ALA or RN utilizing the narcotics What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •RN Monthly chart checklist will be checked off monthly to document any new admissions and their initial medication assessments How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •RN will conduct a monthly chart check and sign off if there is a need for any initial medication assessments	

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{R 821}	Continued From page 31	{R 821}		

and Dilaudid tablets.

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Based on observation and interview, the facility failed to ensure that only residents who self-administered kept medications in their units for three (3) of six (6) residents in the facility. (Residents #1, #2 and #3)

The findings include:

On August 3, 2017, at 10:39 a.m., interview with the ALA revealed that each of the residents had a diagnosis of Dementia and were unable to self-medicate.

Observation of the facility revealed the following:

I. On August 4, 2017, at 9:48 a.m., observation of Resident #1 and #3's bedroom revealed a bottle of Aspirin and a tube of eye drops on Resident #3's dresser. At that time, the TME was asked to remove the medications. The TME then took the medications from the dresser, and secured them in the medication cabinet. The TME stated that the medications belonged to Resident #3.

II. On August 4, 2017, at 1:45 p.m., during an inspection of the medication cabinet, the TME stated that Resident #2's medication was kept in his/her bedroom. When asked to observe where the medication was kept, the TME led the surveyor to Resident #2's bedroom, opened an unlocked closet, and pulled out a small box that contained a box of Fentanyl patches and Dilaudid. The TME then led the surveyor to the resident's unlocked dresser, where she opened an unlocked drawer, and presented a basin which contained Aspirin, Omeprazole, Amliodipine,

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{R 821}	Continued From page 32 Levetiracetam, Atorvastatin, and Risperidone. At that time, the surveyor asked the TME why the medications were kept unsecured in the resident's room. The TME stated that Resident #2 was receiving hospice services, and it was kept in the closet and drawer so it would be easily accessible to the hospice nurse. The TME further stated that there was no key to the closet or drawer. At the time of survey, the facility failed to ensure that only residents who self-administer kept medications in their living units.	{R 821}		
{R 961}	Sec. 1002 1 Fire Safety. (1) An ALR shall be in compliance with Chapter 22, New Residential Board and Care Occupancies, Life Safety Code of the National Fire Protection Association; and Based on record review and interview, the facility failed to have a written fire and emergency plan, for five (5) of 5 residents in the ALR. Findings included: On 11/8/17, at 11:20 AM, during the review of the fire drill records, the ALA was requested to provide the ALR's fire and emergency evaluation plan. The ALA said there was no written fire and emergency plan available for review. At the time of the follow-up visit, the ALR failed to ensure a written fire and emergency plan had been completed. **********	{R 961}	Deficient Practice Category: R961 1.Fire Safety What corrective action(s) will be accomplished to address the identified deficient practice: •ALA has created a written fire and emergency plan for all current residents and is currently on file •ALA will keep on file and updated fire and emergency plan for residence What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur •ALA do monthly update of emergency and fire plan to reflect current resident status and updated changes to residence •ALA and current HHA staff will perform quarterly fire drills for each shift and document each drill How the Corrective action(s) will be monitored to ensure the deficient practice will not recur. •ALR will submit summary to DOH on the 1st of the month	

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{R 961}	Continued From page 33 Based on record review and interview, the facility failed to 1) ensure fire drills were conducted quarterly on each shift; and 2) failed to have a written fire and emergency plan. The findings include: I. On August 3, 2017, at 11:16 a.m., the record of documented fire drills was requested from the ALA. At 12:10 p.m., review of the facility's "Evacuation Drill Record Sheet" revealed a list of fire drills conducted twice per month since December 2016. The list documented times beside each date, however, the times did not specify if they were "a.m." or "p.m." When asked how the fire drills were performed, the ALA stated that some of the residents are just brought to the front door. II. On August 3, 2017, at 11:16 a.m., the facility's emergency plan was requested from the ALA. The ALA responded that the fire department recently visited the facility for an inspection and had no concerns. The ALA further stated that the facility did not have a written fire plan, but she would call the fire department to have one made. When asked how residents could leave the facility in an emergency, the ALA stated that she would call an ambulance to take the resident out of the facility. She then stated that in case of emergency, the aides would carry each of the residents out of the house and across the street to a neighbor's house. It should be noted that the ALA, who was also a HHA, was the only staff scheduled in the facility from 8:00 p.m. to 8:00 a.m. every day. At the time of survey, the facility failed to ensure that fire drills were conducted on each shift	{R 961}		

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{R 961}	Continued From page 34 quarterly, and that there was a written emergency plan for the facility.	{R 961}		
{R9999}	Final Observations The following observations were made during the survey process. It is recommended that this area be reviewed and a determination be made regarding appropriate actions. The findings include: I. On August 3, 2017, starting at 10:05 a.m., an aide was observed in Resident #2's bedroom. The ALA stated that the aide was from a hospice agency. At 10:39 a.m., the same aide was observed to walk into Resident #5's bedroom, to prepare the resident for a bed bath. At 11:10 a.m., interview with the aide revealed that he was employed at a hospice agency as a CNA. He stated that he came to the facility each day to provide care to Resident #2, who was receiving hospice services. He further stated he would stay in the facility to provide care to some of the other residents. At 12:28 p.m., interview with the ALA revealed that the hospice aide had provided services in the facility for about eight (8) months. The ALA then stated that the aide was not an employee, however, she does pay him for the services he provided. When informed that the hospice agency sent the aide to the facility for Resident #2, and he could only provide care for Resident #2, the ALA responded that she was not aware that he could not assist her with other residents while he was in the ALR. She further stated, "I figured since he was licensed, he could bathe other	{R9999}		

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{R9999}	Continued From page 35	{R9999}		

people".

II. On August 9, 2017, starting at 9:00 a.m., an unidentified woman was observed assisting Resident #6 to the rest room. Minutes later, the woman walked out of the bathroom and introduced herself as an aide who was applying for employment at the facility. The aide also stated that the ALA "really needed help", and requested she assist Resident #6 while she was in the facility. Additionally the aide specified that she thought she was coming to the facility to interview for a job.

On August 9, 2017, at 9:11 a.m., interview with the ALA revealed that the aide was going to be a new employee at the ALR. The ALA stated that the aide had previously provided care for Resident #6 at another facility, and was familiar with the resident's needs. When asked if the ALA had verified the aides credentials, she stated, I was just about to get that from her."

At 9:23 a.m., the ALA presented the surveyor a copy of the aide's HHA certification, health certificate, and CPR card. When asked if the aide had received any orientation before working with the resident, the ALA reiterated that the aide was already familiar with the resident. When questioned if the facility's RN was aware that the aide would be hired, the ALA stated, "No, the nurse is only here once a month to do the books."

III. On August 9, 2017, at 10:13 a.m., during the morning medication pass, the TME was observed to prepare Resident #4's medications. The TME was observed to pour Vitamin D3 1000 IU from one bottle into the medication cup. After pouring several other medications into the medication

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cup, the TME picked up a second bottle of Vitamin D3 1000 IU. When the TME opened the bottle, she was stopped by the surveyor and alerted that there was already a Vitamin D3 1000 IU in the medication cup.

At that time, the TME stopped, and checked the group of medication bottles that had already been poured. The TME found the first bottle of Vitamin D3. She then looked at the label and stated, "Oh yes, this is in here. I am not sure why [he/she] has two bottles of it." The TME then stated that she will be more careful when administering medications.

On August 4, 2017, from 10:25 a.m. to 3:00 p.m., review of each resident's medical/administrative record revealed monthly TME medication administration observation forms, that were signed by the facility's nurse. Each form documented that the TME administered medications to each resident without error.

On August 9, 2017, immediately following the 10:13 a.m. medication pass, the TME was questioned if she received any training from the RN regarding medication administration. The TME stated the nurse had not performed a training, but did observe the medication pass monthly.

Completed by: Brandi Abrams, RN
Registered Nurse Signature
Date: January 7, 2018 BA

Assistant Living Administrator Signature: Mary [illegible]
Date: January, 7, 2018